CONTRACT CLOSEOUT REPORT FOR COST REIMBURSEMENT CONTRACTS

State Form 51552 (R / 6-06) / CW 0047
Approved by State Board of Accounts, 2004

See page 2 of this form for completion instructions.

(1) Recipient organization		
Name of organization		
Address (*number and street, city, state, and ZIP code*)		
(2) Name of program	(3) Federal identification number	(4) Contract amount
(5) Contract number	(6) Contract period	

(7) Revenue	
	$
Contract reimbursements - Community Based Family Resource & Support Services	**$**
Older Hoosiers - not applicable	
Program income - not applicable	
In-Kind - not applicable	
Interest - not applicable	
Other (*itemize*) - not applicable	
Community Based Family Resource & Support Services Total Revenue	**$**

(8) Expenditures (by budgeted cost categories) - Community Based Family Resource & Support Services

Category		Budgeted Amount	Total Expenditures
33010.1	Salaries and wages		
33010.2	Fringe benefits		
33010.3	Consultant and contractual services		
33010.4	Space cost		
33010.5	Consumable supplies		
33010.6	Travel		
33010.7	Telephone		
33010.8	Program related expenses		
33010.9	Other cost		
Community Based Family Resource & Support Services Total Expenditures		**$**	**$**
(9) Excess of revenue OR (expenditures)			**$**
(10) Due to DCS and returned herewith (*see page 2*)			**$**

(11) Certification

To the best of my knowledge and belief, this report is true in all respects; and all disbursements have been made for the purpose and conditions of the contract.

To the extent this report could represent a claim for unreimbursed amounts, I hereby certify that the foregoing account is just and correct; that the amount claimed is legally due, after allowing all just credits; and that no part of the same has been paid for the portion of this report which may be used as a claim.

Signature	Date (*month, day, year*)
Printed or typed name and title	Check attached ☐ Yes ☐ No

Remarks

INSTRUCTIONS FOR COMPLETION

(1) Legal name and address of provider organization.

(2) - (6) A report must be completed for each service code for which grant funds have been received.

(7) Report all revenue pertaining to program (2) and corresponding federal identification number (3). Contract grant revenue should include claims receivable as of report date.

(8) Report expenditures for program (2) by cost categories used for claims purposes. Amount should be shown on agency books.

(9) If total revenue exceeds total expenses, enter the difference. If amount paid exceeds expenditures, attach check for that amount. Check should be written to DCS. On the memo section, please write CBFRS. **Please write the contract number on the check.**

(10) If the report shows revenues in excess of expenditures and the amount returned (entered on line 10) is less than excess revenue, please explain in the remarks section. If more space is needed for remarks, use the space below.

(11) This report must be signed and dated by a person having responsibility for the accounting operation.

Reports are due sixty (60) days after contract closing date.

Mail this report together with a check made payable to DCS (*if applicable*) to:

Department of Child Services
402 W. Washington St. Room W364
Indianapolis, IN 46204
Attn: Jill Larimore, MS08

Questions regarding the completion of this form may be directed to: Jill Larimore at (317) 232-2477or via e-mail at Stephanie.Larimore@dcs.IN.gov.

ADDITIONAL REMARKS

FOR DCS USE ONLY

Date received by program (*month, day, year*)	Date received by claims (*month, day, year - if requested*)
Claims verification remarks	
Date verified copy sent to program (*month, day, year*)	